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from the Bureau of Long-Term Support

An "At-A-Glance" Summary of Most of 2006 Financial Eligibility / Rates in Long Term Support

The purpose of this bulletin is to provide care managers and others with an "at-a-glance" review of rates and financial standards for 2006 in various long term support programs. All of the information presented here is published in separate, individual memos from a variety of sources in the Division of Disability and Elder Services and the Division of Health Care Financing; the source document should be reviewed for detail.

I. Medicaid Home and Community Based Services Waiver

Medicaid Waivers are a source of funding for long term support services for persons who are otherwise eligible for Medicaid funded institutional care. Waiver funding enables the arrangement of comprehensive services for persons living in the community. Community Integration Programs 1A and 1B serve persons with developmental disabilities. Community Integration Program II (CIP II) and Community Options Program Waiver (COP-W) serve persons who are elderly or have a physical disability. See section VIII for Children Long Term Support Waivers.

A. The State Maximum Per Diem Average for Community Integration Program II (CIP II) and Community Options Program-W (COP-W) is $41.86/day.

- Counties are reimbursed fully for expenses for each CIP II participant up to the county's contract level. The contract is based on an average of $41.86 per "slot." A per diem variance may be available. CIP II Community Relocation funding is not included in the per diem average.
- For COP-W the state match is available to counties as an annual fixed allocation. Counties may spend an average of $41.86/day for COP-W, but the per diem and number of individuals served in COP-W is limited by the allocation or the availability of additional local match.

B. Community Integration Programs 1 A/B, Brain Injury Waiver Federal Per Diem Rates for Current and New Slots.

The following chart lists the "state matched Medicaid per diem[1]" associated with each different type of CIP 1A, 1B/1B ICF-MR and BIW slot. It also provides information on both the federal and local Medicaid matching percentage rates.

[1] "State matched per diem" refers to the amount of funding earned by a county for each day a CIP 1A, CIP 1B or Brain Injury Waiver slot is actually in use by an eligible participant. These Medicaid dollars are composed of federal Medicaid funds and state general purpose revenues used as match and include no local matching funds.

Both of these rates will be applied to claims for all allowed service and administrative costs which are on average above the state Medicaid per diem. The federal Medicaid matching percentage is used to determine the amount of additional federal funding the county will receive to reimburse their costs above the matched per diem. The local Medicaid matching percentage is used to determine the amount of local matching funds needed to qualify for these additional federal funds.

2006 Rates	CIP 1A Regular Slots			CIP 1B Regular Slots/ 1B ICF-MR As of 7/01/02	CIP 1B Locally Matched Slots	Brain Injury Waiver All Slots As of 7/1/02	Brain Injury Waiver Local Match As of 7/1/02
	Per Diems	From:	To:				
Slot per diem amt. Reimbursed by matched Medicaid funds: Jan/Dec. 2002	$125.00 $153.00 $184.00 $190.00 $200.00 $225.00 $325.00 $325.00	**Prior to** 7/1/95 7/1/97 7/1/00 7/1/01 7/1/02 7/1/03 7/1/04	7/1/95 6/30/97 6/30/00 6/30/01 6/30/02 6/30/03 6/30/04 ongoing	$49.67 and Facility/ Plan Specific Rates	0	$180.00	0
% of ALL costs* above amt. on row one partially paid by federal share of Medicaid	57.43%	57.43%	57.43%	57.43%	57.43%	57.43%	57.43%
% of ALL costs* above amt. on row one partially paid by local funds	42.57%	42.57%	42.57%	42.57%	42.57%	42.57%	42.57%

* State/federal percentages are subject to change per notification from Centers for Medicare and Medicaid Services.

C. Brain Injury Waiver (BIW)

Beginning January 1, 1995, Medicaid eligible persons who meet the definition of brain injury as a developmental disability under s. 51.01 (2g). Stats., and who are receiving or are eligible for post acute rehabilitation institutional care may receive community services in this Medicaid Waiver. The Brain Injury website may be accessed at: http://dhfs.wisconsin.gov/bdds/brain.htm

D. Medicaid Waiver Income, Asset, and Cost-sharing Amounts

To be eligible for a Medicaid Waiver, each individual must meet income and asset tests. Eligible persons are protected by spousal impoverishment legislation. Once a person begins participating in a Medicaid Waiver program, a certain amount of income is protected in order to pay for room, board, and personal expenses (personal maintenance allowance). Certain additional deductions from income apply (e.g., medical/remedial expenses, specified court-ordered expenses), and remaining funds are subject to cost-sharing. The following limits apply to all Medicaid Waivers: Community Options Program-W, Community Integration Programs II, 1A and 1B, and Brain Injury Waiver.

2006 Medicaid Waivers Monthly Income Limits	Asset Limits
Group A - Eligible for "full benefit" Medicaid subprogram, or Group B - Eligible under a special income limit of up to **$1,809** Group C – Medically Needy (Income above $1,809 but incurs enough medically related expenses to reduce income to the medically needy income limit ($591.67) Spousal Impoverishment Income and Asset Protections apply as explained below.	• $ 2,000 for a "single"* individual • See below for Spousal Impoverishment Protections

* Single means: unmarried, legally separated or, under spousal impoverishment, having been on the program for 12 months or more.

2006 Spousal Asset Protection Amounts

If a couple's combined assets are:	At-home (community) spouse may keep:
$0 - $50,000	ALL
$50,001 - $100,000	$50,000
$100,001 - $199,080	HALF of the combined assets
Over $199,080	$99,540

Spousal Impoverishment Asset Protections

Protections apply as follows:

Applicant / Participant	Applicant/Participant's Spouse	Do spousal impoverishment rules apply?
Residing in a medical institution for 30 or more days	In community	YES
	Residing in a medical institution for 30 or more days	NO
	Participating in a community waiver program	YES
Participating in a community waiver program	In community	YES
	Residing in a medical institution for 30 or more days	NO
	Participating in a community waiver program	YES

Note: When both spouses are on waivers, after each spouse has been a waiver participant for 12 months and s/he continues to be a waiver participant, s/he is considered to be "single" and must have no more than $2,000 in countable assets to remain eligible for community waivers.

2006 Spousal Impoverishment Income Protections

Minimum Monthly Spousal Income Allocation	$2,081.67*
Maximum Monthly Spousal Income Allocation	$2,488.50
Maximum Monthly Family Member Income Allocation	$534.58*

* Amount changes around March of each year

2006 Cost-Sharing Amounts

Minimum Personal Maintenance Allowance	$783.00
Maximum Personal Maintenance Allowance	$1,809.00

II. Regular Community Options Program Financial Eligibility

Six Month Resource Allowance:

Each adult applicant/participant: $ 34,120.00
Each child applicant/participant: $125,377.00

Monthly Income Allowance for "Resident's" Spouse:
(Applicant/participant is a resident of an adult family home, CBRF, nursing home, or other institution)

Spouse is a community spouse $2,488.50

Spouse is also on COP or Medicaid Waivers $1,596.00

Irrevocable Burial Trusts
Effective July 1, 2003, the amount of funds which may be kept in an irrevocable burial Trust was raised from $2,500 to $3,000.

Divestment Amount for 2006 $ 5,338.00

III. Regular Community Options Program Service Expenditures

The "regular" Community Options Program is state-funded and is designed to divert or relocate individuals of all age/target groups from nursing homes. For those counties whose average caseload costs may exceed the state share of nursing home costs of $1,595/month, a variance to the rate is usually possible because statewide average spending remains well below this allowable maximum.

Average Reimbursement Rate for Regular Community Options

1994	$880/month
1995	$965/month

1996	$974/month
1997	$998/month
1998	$1,043/month
1999	$1,056/month
2000	$1,147/month
2001	$1,095/month
2002	$1,253/month
2003	$1,256/month
2004	$1,395/month
2005	$1,492/month
2006	$1,595/month

IV. Residential Care Apartment Complexes (RCAC)

State statutes limit the amount of waiver funds that can be spent on supportive, personal, and nursing services provided to an individual residing in a state certified RCAC to an amount not to exceed 85 percent of the statewide average daily cost of Medicaid reimbursement for nursing home care. The reimbursement rate for 2005 is $82.05. The ***proposed*** increase for 2006 is $87.51. When this rate is approved, counties will be notified. This is not a rate for RCACs: actual funding may be less than $82.05 as determined by Medicaid waiver reimbursement limits, based on services needed by each resident. COP is not an allowable funding source for RCACs.

V. Supplemental Security Income (SSI) Payment Levels for 2006

SSI is a national program of monthly cash payments for people who are elderly or have a disability and who have limited income and assets. It consists of a basic federally-funded payment level with a state-funded and state-determined supplement.

The new SSI payment levels listed below are effective January 1 through December 31, 2006. The 2006 federal SSI benefit rates reflect a cost of living adjustment increase. The state supplement to the federal SSI has remained the same since 1998. The asset limit remains unchanged at $2,000 for an individual and $3,000 for a couple.

The state has contracted with EDS to implement the state administration of the state supplement. Other than those in a work incentive program or those grandfathered in 1995, a person must be eligible for some federal benefit in order to receive the state supplement.

SSI Payment Rates Effective **January 1, 2006**

Living Arrangement		Federal Benefit	State Supplement	Total Payment
A. Own Household:	INDIVIDUAL	$603.00	$ 83.78	$ 686.78
	COUPLE	$904.00	$132.05	$1,036.05
B. Household of Another:	INDIVIDUAL	$402.00	$ 83.78	$ 485.78
	COUPLE	$602.67	$132.05	$ 734.72
C. Own Household with Ineligible Spouse:				
	INDIVIDUAL	$603.00	$130.43	$ 733.43
D. Household of Another with Ineligible Spouse:				

Living Arrangement	Federal Benefit	State Supplement	Total Payment
INDIVIDUAL	$402.00	$135.05	$ 537.05
E. Exceptional Expense Supplement (SSI-E):			
INDIVIDUAL	$603.00	$179.77	$ 782.77
COUPLE	$904.00	$477.41	$1,381.41
F. SSI Caretaker Supplement Effective November 1, 1999	$250 for the first eligible child and $150 for each additional eligible child		

Source: State SSI Coordinator, Division of Disability and Elder Services

SSI, "Own Household," (A above), includes individuals who live alone as well as individuals who live with others but pay their proportionate share of food, shelter and utility costs. SSI, "Household of Another," (B above), includes only those individuals or couples living with others and receiving in-kind support, i.e., not paying their proportionate share of household expenses. The Social Security Administration reduces the federal benefit by one third in lieu of calculating the actual value of in-kind support received. SSI, "Ineligible Spouse," (C above), means that one member of a couple is aged, blind, or disabled and the other member is not any of these.

The SSI-"E" supplement is available to SSI recipients who need at least 40 hours a month of assistance with activities of daily living and are certified by county agencies or their designees. Effective July 1, 2000, in addition to individuals who live in their own homes or the home of another, SSI individuals who reside in the following community settings may be eligible for this supplement:

- DHFS certified Residential Care Apartment Complexes (RCACs)
- Community Based Residential Facilities (CBRFs) certified as consisting entirely of independent apartments, regardless of size
- Effective July 1, 2002, in CBRFs with up to 20 beds, and
- Adult Family Homes either licensed by DHFS or certified by county agencies.

VI. Caretaker Supplement

Payments for this supplement—which is paid with the State SSI check to SSI eligible caretaker parents—is $250 for the first child and $150 for each additional child. Eligibility for this supplement is determined as part of the Medicaid eligibility process for the qualified children at county human and social services agencies. More information is available by contacting the county agency or by calling the SSI Helpline at 1-800-675-0249. The program's website may be accessed at: http://dhfs.wisconsin.gov/ssi/CaretakerHandbook/index.htm

VII. Katie Beckett Program

The Katie Beckett Program is a Medicaid subprogram for certain children who have long term disabilities or complex medical needs and who live at home with their families. Unlike regular Medicaid, where a portion of parental income and assets are considered to be available to the child for eligibility purposes, under the Katie Beckett Program parental income and assets are disregarded. ***Only the child's income and assets are considered***, and these cannot exceed the standards for a person in an institution. The income standard is indexed to three times the federal payment rate for an individual on SSI.

Katie Beckett Child's Maximum Monthly Income Limit	$1,809.00
Katie Beckett Child's Maximum Asset Limits	$2,000.00

The program's website may be accessed at: http://dhfs.wisconsin.gov/bdds/kbp/index.htm

VIII. Children's Long-Term Support Home and Community-Based Services Waivers (CLTS Waivers)

The Children's Long-Term Support Home and Community-Based Services Waivers (CLTS Waivers) began on January 1, 2004. Three CLTS Waivers were approved by the Centers for Medicaid and Medicare Services (CMS) and differ mainly by their target population; there is one Waiver for children with developmental disabilities, one for children with mental health disabilities, and one for children with physical disabilities. Children ages birth to age 22 are eligible; children must meet functional and financial eligibility criteria. For more information on the CLTS Waivers, please see: http://dhfs.wisconsin.gov/bdds/clts/index.htm

2006 Rates for CLTS Waivers	CLTS DD & SED. Waivers – Intensive Autism Services As of 1/1/04	CLTS DD, SED & PD Waivers – Autism Services – Ongoing Level As of 1/1/04	CLTS DD, SED & PD Waivers – Crisis and Pilot Slots As of 1/1/04	CLTS DD, SED & PD Waivers – Local Matched Slots
Slot per diem amt. Reimbursed by matched Medicaid funds:	Authorized level of therapy, case management & Admin	$30.60/day	$48.42/day	0
% of ALL costs* above amt. on row one partially paid by federal share of Medicaid	57.43%	57.43%	57.43%	57.43%
% of ALL costs* above amt. on row one partially paid by local funds	42.57%	42.57%	42.57%	42.57%

* State/federal percentages are subject to change per notification from Centers for Medicare and Medicaid Services.

IX. Medicaid Rates for Personal Care, Home Health Agency, Private Duty Nursing, Etc.

The updated Medicaid Maximum Allowable Fees for personal care, home health agencies, and private duty nursing may be found at: http://dhfs.wisconsin.gov/medicaid4/maxfees/maxfee.htm#Home%20Health
The fees for these services are on one fee schedule, broken down by procedure code. Look for the type of services you need the fees for (e.g., personal care), and look for the procedure codes for that provider type.

X. Medicaid Reimbursement Rates for Prescription Drugs

The following section applies only to waiver participants who are not eligible or are not enrolled in Medicare. For waiver participants who are eligible or who are enrolled in Medicare, see COP Information Bulletin # 172, dated May 19, 2005.

Medicaid reimbursement rates for prescription drugs are as follows:

1. For *brand name* drugs (non-generic), reimbursement is average wholesale price (AWP) minus a variable percentage discount established by the Wisconsin State Legislature. AWP of products is not determined by nor published by Medicaid. It is an extensive national listing updated twice a month, and published by First Data Bank. Medicaid loads the information into their database, and pays the price minus the discount. Pharmacists receive the AWP listings. For care managers who process Group C waiver participants (except for dually eligible Group C), the simplest way to identify Medicaid reimbursement for brand name drugs would be to ask a pharmacy to look up the AWP for a particular drug and then deduct the current discount amount.
2. Most *generic* drugs are on the Legend Drug Maximum Allowed Cost (MAC) list, which is published monthly on the web and can be found at: http://dhfs.wisconsin.gov/medicaid4/pharmacy/data_tables/index.htm

XI. Medicaid Co-payments

Individuals who are new to the Medicaid program are informed about Medicaid co-payments during the application process. Care managers may also want to remind new clients about the existence of Medicaid co-payments. Co-payments range from $0.50 to $3.00 and are based on the cost of the service received. Certain services are exempt from co-payment (e.g., emergency services, services provided to nursing home residents, etc.).
Information for recipients regarding Medicaid co-payments can be found in the site map under "**Updates"** at: http://dhfs.wisconsin.gov/medicaid1/index.htm
Information for providers regarding Medicaid co-payments can be found in the Recipient Eligibility Section of the All Provider Handbook:
http://dhfs.wisconsin.gov/medicaid1/recpubs/eligibility/book_e.htm#copayments

If you have questions about Medicaid Updates and/or the Medicaid Maximum Fee Schedule, contact Medicaid Recipient Services: 1-800-362-3002 or (local) 608-221-5720.

XII. Medicare 2006 Updates

Part A – Covers inpatient hospital, skilled nursing, post-institutional home health care, and hospice.

Part A Premium
Most people do not pay a monthly Part A premium because they or a spouse has 40 or more quarters of Medicare-covered employment. For persons who do not meet these criteria, they will pay:

- $216.00 for people having 30-39 quarters of Medicare-covered employment.
- $393.00 per month for people who are not otherwise eligible for premium-free hospital insurance and have less than 30 quarters of Medicare-covered employment.

Part A Deductible and Coinsurance Amounts

- Hospital
  - Deductible: $ 952.00
  - Co-Insurance: 1st through 60th day: $0
    61st through 90th day: $238.00/day
    91st through 150th day: $476.00/day
- Skilled Nursing Facility
  - Co-Insurance: 1st through 20th day: $0
    21st through 100th day: $119.00/day

Part B – Covers physician services, outpatient hospital, durable medical equipment, and other medical services.

Part B Premium—$88.50 per month.

Part B Deductible—$124.00 per year

Part B Co-insurance
After the $124 deductible is met, beneficiaries are responsible for 20 percent co-insurance of the Medicare approved amount.

Part D – Covers prescription medicines.

Effective 1/1/06, Part D of Medicare will offer prescription drug coverage through private insurers. Cost and coverage varies.

Dually eligible Medicaid Waiver participants (i.e., waiver participants who are eligible or who are enrolled in Medicare), will no longer receive prescription drug coverage through Medicaid, with the exception of benzodiazepines and barbiturates and a few over the counter medicines. Instead, they will be automatically enrolled in a low cost Medicare Part D Plan, unless they select one independently and enroll in it prior to December 31, 2005.

Please consult COP Information Bulletin # 172, dated May 19, 2005, for additional information regarding dually eligible Medicaid Waiver participants.

Information about Medicare Part D is also accessible at:

http://www.cms.hhs.gov/partnerships/

http://www.medicare.gov/

http://www.medicare.gov/spotlights.asp#medicare2006

If you have questions about Medicare regarding participants who are 60 and older, contact your county's Elderly Benefit Specialist, located either in the County Aging Office or in the Human Services or Social Services Department.